

Items 8,9 FilmG281 2-27-61 et

# CERTIFICATE OF DEATH

Reg. Dist. No. 01770

## MEDICAL CERTIFICATION

VS A15 (4)  
15M 9/55



1796

## CERTIFICATE OF DEATH

Reg. Dist. No. 01775

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Warwick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS --			
3. NAME OF DECEASED (Type or print) First Middle Last Baby Lee Biddle Jr.				4. DATE OF DEATH Month Day Year February 3, 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 2, 1961	
9. AGE (In years last birthday) yrs.		10. AGE (In years last birthday) yrs.		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baby				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Lee Biddle				14. MOTHER'S MAIDEN NAME Alma Reed			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None				16. SOCIAL SECURITY NO. Lee Biddle, Address Warwick, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 760.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral hemorrhage, premature separation of placenta. INTERVAL BETWEEN ONSET AND DEATH 36 hours.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 02 Feb 1961 to 3 Feb 61 1961, that I lost sows the deceased alive on 3 Feb 61 1961, and that death occurred at 3:15 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cecilton, Md. DATE SIGNED 6 Feb 61 ACTUAL SIGNATURE Wallace Obenshain M.D. M.D. PHYSICIAN'S NAME (Type) Wallace Obenshain, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Feb. 6, 1961			
22c. NAME OF CEMETERY OR CREMATORY Cecilton Cemetery				22d. LOCATION (City, town, or county) (State) Cecilton, Cecil Co; Md.			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Edward Fellows, Millington, Md.				24a. REG. BY REGISTRAR DATE Feb 8, 61			
24b. REGISTRAR'S SIGNATURE							

1888

RECEIVED

1888

1888

1888

1888

1888

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1797

## CERTIFICATE OF DEATH

Reg. Dist. No. 01776

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 2 wks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural R. D. 3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS Elkton		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SARAH Middle SERESSA Last BOWLSBEY				4. DATE OF DEATH Month February Day 20 Year 19 61			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 14, 1887		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired -		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Zain Bedwell				14. MOTHER'S MAIDEN NAME Sarah Cloude			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-14-8447		INFORMANT Address Mr. Joseph W. Bowlsbey, R. D 3, Elkton			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1 Bronchiogenic carcinoma, right with intermittent attacks of bronchitis DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH About 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerotic vascular disease							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 19 1961, to Feb. 20 1961, that I last saw the deceased alive on Feb. 19 1961, and that death occurred at 3:40 a. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE S. Ralph Andrews, jr.		M.D.		ADDRESS (Street, city or town, state) 233 E. Main Street		DATE SIGNED 2/20/61	
PHYSICIAN'S NAME (Type) S. Ralph Andrews, jr., M.D.		Elkton, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/23/61		22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		22d. LOCATION (City, town, or county) (State) Elkton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks				ADDRESS Elkton, Maryland		24a. REC'D BY REGISTRAR DATE MAR 1 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thoms			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1798

CERTIFICATE OF DEATH

Reg. Dist. No. 01777

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Port Deposit, Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Devine Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Florence Charsha Brown		4. DATE OF DEATH Feb. 23 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 11, 1880
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James H. Charsha		14. MOTHER'S MAIDEN NAME Elizabeth Reburn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Wilmer E. Brown, Port Deposit, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary artery heart disease with severe atherosclerosis (b) Deeply atherosclerotic (c) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Unknown Interval between onset and death Unknown		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 14, 1958, to Feb. 23, 1961, that I last saw the deceased alive on Feb. 22, 1961, and that death occurred at 4 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE [Signature]		ADDRESS (Street, city or town, state) DATE SIGNED 2/24/61	
PHYSICIAN'S NAME (Type) J. RALPH A. HODGINS, M.D.		Elkton, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-27-1961	
22c. NAME OF CEMETERY OR CREMATORY West Nottingham Cem.		22d. LOCATION (City, town, or county) (State) Coloma, Md. Rural	
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son		ADDRESS Perryville, Md.	
24a. REC'D BY REGISTRAR DATE FEB 27 '61		24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR FUNERAL HOME: This certificate must be completed and signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1528

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1799

## CERTIFICATE OF DEATH

Reg. Dist. No. **01778**

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <span style="float: right;">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> <span style="float: right;">b. COUNTY <b>Cecil</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>				e. STREET ADDRESS <b>1221 West Main Street,</b>			
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>ALFRED</b> Last <b>CLARK</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>9,</b> Year <b>1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 18, 1873</b>	9. AGE (In years last birthday) <b>88</b> yrs.	IF UNDER 1 YEAR Months <b>88</b> Days <b>88</b> Hours <b>88</b> Min.	IF UNDER 24 HRS. Months <b>88</b> Days <b>88</b> Hours <b>88</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Store</b>		11. BIRTHPLACE (State or foreign country) <b>Elkton, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James A. Clark</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Cannan</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-03-7869</b>		INFORMANT Address <b>John A. Clark, Jr. Wilmington, Del.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Meningitis</b> DUE TO (c) <b>Carcinoma of Prostate</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2-18-61</b> <b>2-19</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Prostate Obstruction</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Glauco Maresca</b> M.D. <b>265 W. Main Street,</b> <b>2-9-61</b>							
ACTUAL SIGNATURE <b>Glauco Maresca</b>							
PHYSICIAN'S NAME (Type) <b>Glauco Maresca</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-13-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Elkton Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Elkton, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>PIPPIN FUNERAL HOME</b>				ADDRESS <b>Elkton, Md.</b>		24c. REC'D BY REGISTRAR <b>FEB 14 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. H.</b>			

TO HOSPITAL AND FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1891

1891

The following is a list of the names of the students who were admitted to the college in the year 1891. The names are arranged in alphabetical order.

1. Adams, John

2. Allen, William

3. Anderson, James

4. Baker, George

5. Baker, Thomas

6. Baker, William

7. Baker, John

8. Baker, James

9. Baker, George

10. Baker, Thomas

11. Baker, William

12. Baker, John

13. Baker, James

14. Baker, George

15. Baker, Thomas

16. Baker, William

17. Baker, John

18. Baker, James

19. Baker, George

20. Baker, Thomas

21. Baker, William

22. Baker, John

23. Baker, James

24. Baker, George

25. Baker, Thomas

26. Baker, William

27. Baker, John

28. Baker, James

29. Baker, George

30. Baker, Thomas

31. Baker, William

32. Baker, John

33. Baker, James

34. Baker, George

35. Baker, Thomas

36. Baker, William

37. Baker, John

38. Baker, James

39. Baker, George

40. Baker, Thomas

41. Baker, William

42. Baker, John

43. Baker, James

44. Baker, George

45. Baker, Thomas

46. Baker, William

47. Baker, John

48. Baker, James

49. Baker, George

50. Baker, Thomas

51. Baker, William

52. Baker, John

53. Baker, James

54. Baker, George

55. Baker, Thomas

56. Baker, William

57. Baker, John

58. Baker, James

59. Baker, George

60. Baker, Thomas

61. Baker, William

62. Baker, John

63. Baker, James

64. Baker, George

65. Baker, Thomas

66. Baker, William

67. Baker, John

68. Baker, James

69. Baker, George

70. Baker, Thomas

71. Baker, William

72. Baker, John

73. Baker, James

74. Baker, George

75. Baker, Thomas

76. Baker, William

77. Baker, John

78. Baker, James

79. Baker, George

80. Baker, Thomas

81. Baker, William

82. Baker, John

83. Baker, James

84. Baker, George

85. Baker, Thomas

86. Baker, William

87. Baker, John

88. Baker, James

89. Baker, George

90. Baker, Thomas

91. Baker, William

92. Baker, John

93. Baker, James

94. Baker, George

95. Baker, Thomas

96. Baker, William

97. Baker, John

98. Baker, James

99. Baker, George

100. Baker, Thomas

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 012779

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City		c. LENGTH OF STAY IN 1b 4 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Morgans Nursing Home		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Thomas Nelson Collyer		4. DATE OF DEATH February 8 Day Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 19-1876
9. AGE (In years last birthday) 84		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas N. Collyer		14. MOTHER'S MAIDEN NAME Mary Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Mrs. Beulah Collyer--Rock Hall, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan. 2, 1961</i> to <i>Feb. 8, 1961</i> , that I last saw the deceased alive on <i>Feb. 8, 1961</i> , and that death occurred at <i>3:30 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Henry G. Davis</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <i>2/8/61</i>	
PHYSICIAN'S NAME (Type) HENRY G. DAVIS M.D.		CITY, STATE, AND ZIP CODE <i>CHESAPEAKE CITY MD 20759</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF Feb. 11	22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel	22d. LOCATION (City, town, or county) (State) Rock Hall Maryland
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar L. Lane</i> ADDRESS Church Hill, Maryland		24a. REC'D BY REGISTRAR DATE FEB 10 '61	24b. REGISTRAR'S SIGNATURE <i>Collyer P. Jones</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

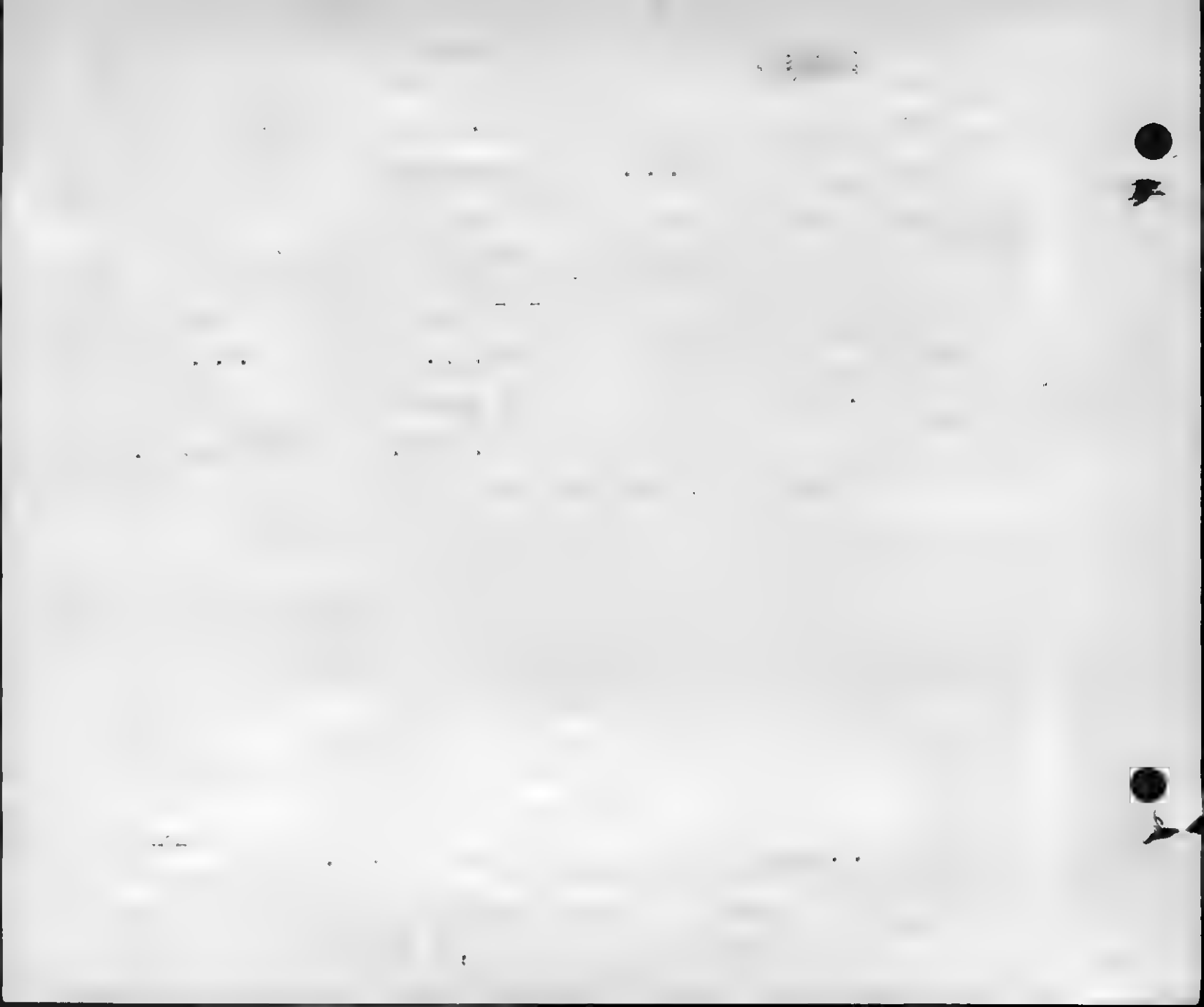
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is required, the body should be preserved in a refrigerator. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM  
5/1/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**180 MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 01280

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesapeake City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>				c. LENGTH OF STAY IN 1b <b>D.O.A.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hosp.</b>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mart in Eugene Crain</b>				4. DATE OF DEATH Month Day Year <b>2 1 61</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-18-60</b>	
9. AGE (In years last birthday) <b>4</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		11. BIRTHPLACE (State or foreign country) <b>Elkton, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>Wiley M. Crain</b>				14. MOTHER'S MAIDEN NAME <b>Lilly Burchan</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMATION <b>Wiley M. Crain, Chesapeake City, Md.</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>490X</b> IMMEDIATE CAUSE (a) <b>Pneumonia Bilateral</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>R.C. Dodson</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>2/4/ 1961</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Cherry Hill Cemetery</b>				22d. LOCATION (City, town, or country) (State) <b>Cherry Hill, Maryland</b>			
23. FUNERAL DIRECTOR <b>PIPPIN FUNERAL HOME</b>				24a. REC'D BY REGISTRAR <b>Rising Sun, Md.</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>				DATE <b>FEB 6 '61</b>			

X



TO HOSPITAL OR BATHING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1802

CERTIFICATE OF DEATH

01781

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Delaware b. COUNTY 1	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Md.		c. LENGTH OF STAY IN 1b 11mo. 20 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS RFD #2	
3. NAME OF DECEASED (Type or print) First MIDDLE Last GILBERT M. DIXON		4. DATE OF DEATH Month Day Year February 28 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-12-94
9. AGE (In years lost birthday) 66 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Dixon		14. MOTHER'S MAIDEN NAME Elizabeth Shahan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW-L		16. SOCIAL SECURITY NO. 215-20-1432	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Bronchopneumonia, bilateral, unresolved DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Arteriosclerotic heart disease DUE TO (c) unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2-3 days INTERVAL BETWEEN ONSET AND DEATH unknown		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>XXXXX</del> attended the deceased from March 8 1960 to February 28 1961. <del>XXXXX</del> was the deceased since <del>XXXXX</del> and that death occurred at 1:30 pm from the causes and on the date stated above.			
22a. SIGNATURE A.L. Mooney M.D.		22b. DATE SIGNED 3-1-61	
22c. PHYSICIAN'S NAME (Type) A.L. MOONEY		22d. ADDRESS Asst. Clinical Pathologist, VAH, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 3/3/61		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Millington		23d. LOCATION (City, town, or county) (State) Millington, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR	
Perrington & Son, Havre de Grace, Md.		DATE MAR 6 '61	
25b. REGISTRAR'S SIGNATURE		G. L. H. H. H.	



1803

## CERTIFICATE OF DEATH

Reg. Dist. No.

01782

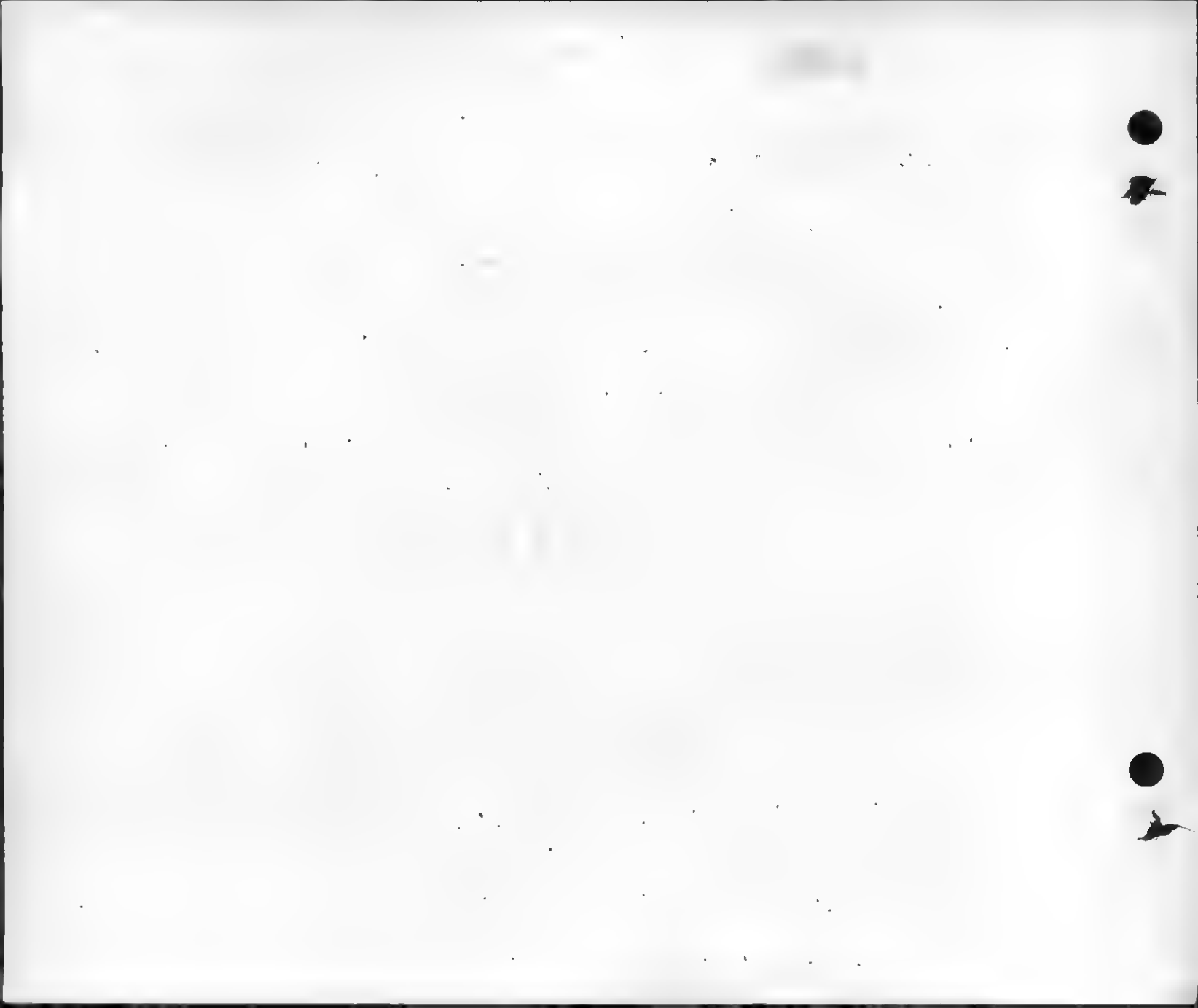
1 PLACE OF DEATH o. COUNTY <i>Cecil</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Calvert</i> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Cecil</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rising Sun</i> d. STREET ADDRESS <i>Cherry Street</i>	
3 NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>Alice</i> Last <i>Green</i>		4. DATE OF DEATH Month <i>Feb.</i> Day <i>7</i> Year <i>1961</i>	
5 SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 6, 1884</i>
9. AGE (In years last birthday) <i>76</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Dressmaker/Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Albert Winters</i>	
14. MOTHER'S MAIDEN NAME <i>Barbara Rhinehart</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Genevieve Lockford, Newark, Del.</i>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Myocardial</i> <i>422</i> DUE TO <i>Ischemic Arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Ischemic Arteriosclerosis</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <i>7-1</i> 19 <i>60</i> , to <i>2-7</i> 19 <i>61</i> that I last saw the deceased alive on <i>Feb 8, 1961</i> , and that death occurred at <i>11:01</i> M, from the causes and on the date stated above.	
ACTUAL SIGNATURE <i>R. C. Dodson</i> M.D.		ADDRESS (Street, city or town, state) <i>Rising Sun, Md.</i>	
DATE <i>FEB 9 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	
22a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Feb 10, 1961</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Hopewell Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Port Deposit, Md.</i>	
23 FUNERAL DIRECTOR'S SIGNATURE <i>Ralph M. Reed, Rising Sun, Md.</i>		ADDRESS	

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

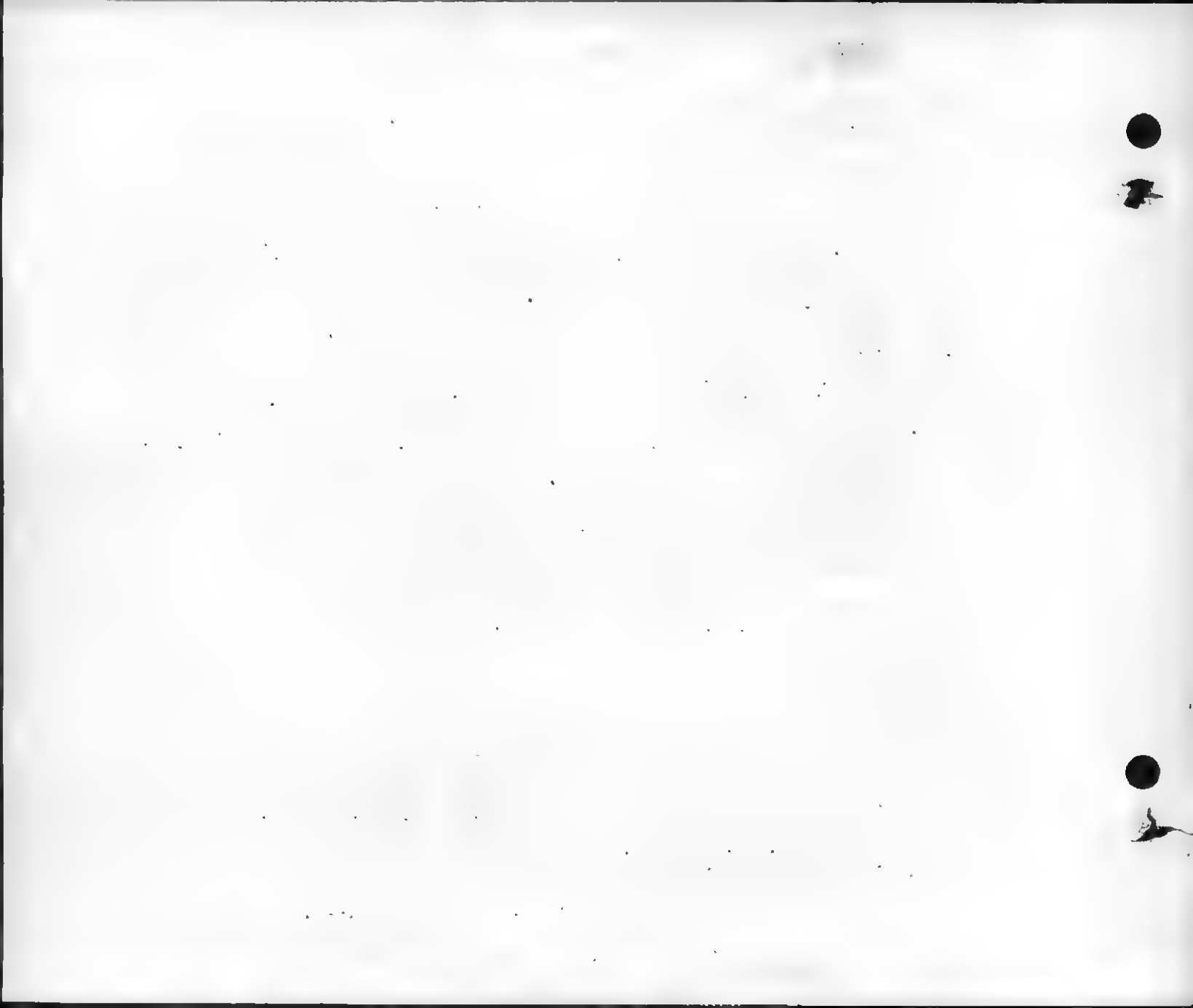
## 1804

## CERTIFICATE OF DEATH

Reg. Dist. No. **1783**

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before adm ssion) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rising Sun</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rising Sun Md.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1 S. Queen</b>			
3. NAME OF DECEASED (Type or print) First <b>Alma</b> Middle <b>M</b> Last <b>Keilholtz</b>				4. DATE OF DEATH Month <b>February</b> Day <b>3</b> Year <b>1961</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 6, 1877</b>	9. AGE (In years last birthday) <b>83</b> yrs.	10. UNDER 1 YEAR Months Days Hours Min		11. UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bookkeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bank</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry C Keilholtz</b>				14. MOTHER'S MAIDEN NAME <b>Mary H. Scott</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-164398</b>		INFORMANT <b>Chalmers McFarren, Rising Sun, Md.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>hypertension</b> <b>45x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>major accident</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>arterio sclerosis</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10-4</b> , 19 <b>60</b> , to <b>2-3</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>2-2</b> , 19 <b>61</b> , and that death occurred at <b>1444</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Ralph M. Reed</b> M.D.				ADDRESS (Street, city or town, state) <b>Rising Sun Md</b> DATE SIGNED <b>2-3-61</b>			
PHYSICIAN'S NAME (Type) <b>R. E. DODSON MD</b>							
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 6, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hopewell Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Port Deposit, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ralph M Reed, Rising Sun, Md.</b> ADDRESS				24a. REC'D BY REGISTRAR <b>FEB 7 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

Page 4  
The law requires that the death certificate be executed within 24 hours after death.  
TO HOSPITAL OR NURSING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

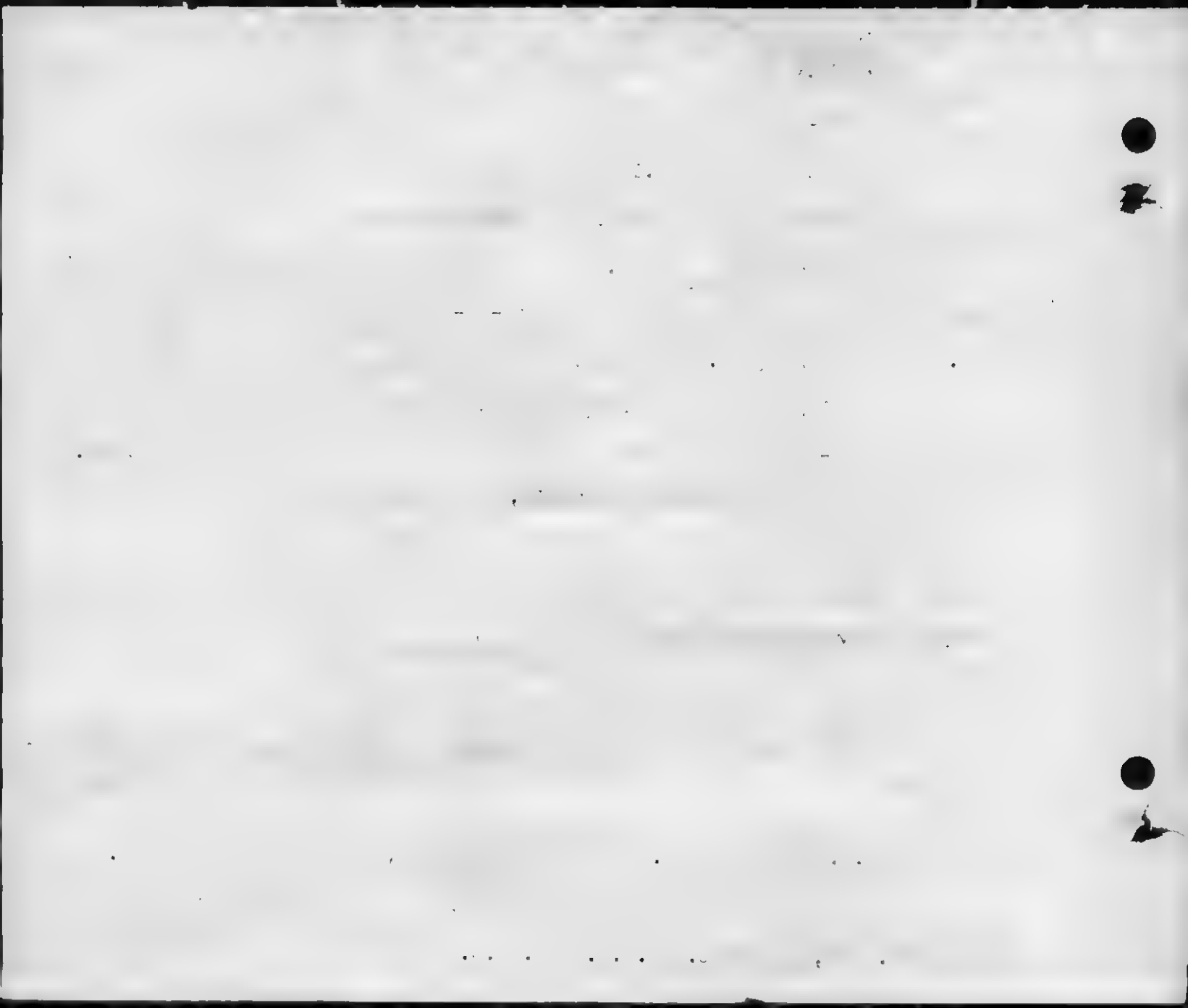
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

1805

01784

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Cecil</u> <span style="float: right;">MARYLAND</span>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institutions; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>5mo. 18days</u>		d. STREET ADDRESS <u>4971 Battery Lane</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>WILLIAM R. KELLY</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>February 20 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-24-09</u>
9. AGE (In years last birthday) <u>51 yrs.</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dept. of Agriculture (Ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US Government</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>New York City</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Denis Kelly (deceased)</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Murray (deceased)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW-II</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Hospital Records, VAH, Perry Point, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia, bilateral unresolved</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Degenerative cerebral disease (Alzheimer's disease)</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I of Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>VA 19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <u>XXXXXX</u> attended the deceased from <u>September 2 1960</u> to <u>February 20 1961</u> and that death occurred <u>10:15am</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>A.L. Mooney</u>		22b. DATE SIGNED <u>FEB 27 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>A.L. MOONEY</u>		22d. ADDRESS <u>Asst. Clinical Pathologist, VAH, Perry Point, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>24 FEB 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>DE VOL FUN. HOME, 2224 Wisc. Ave. N.W. Wash. D.C.</u>		25a. REC'D BY REGISTRAR <u>FEB 27 1961</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

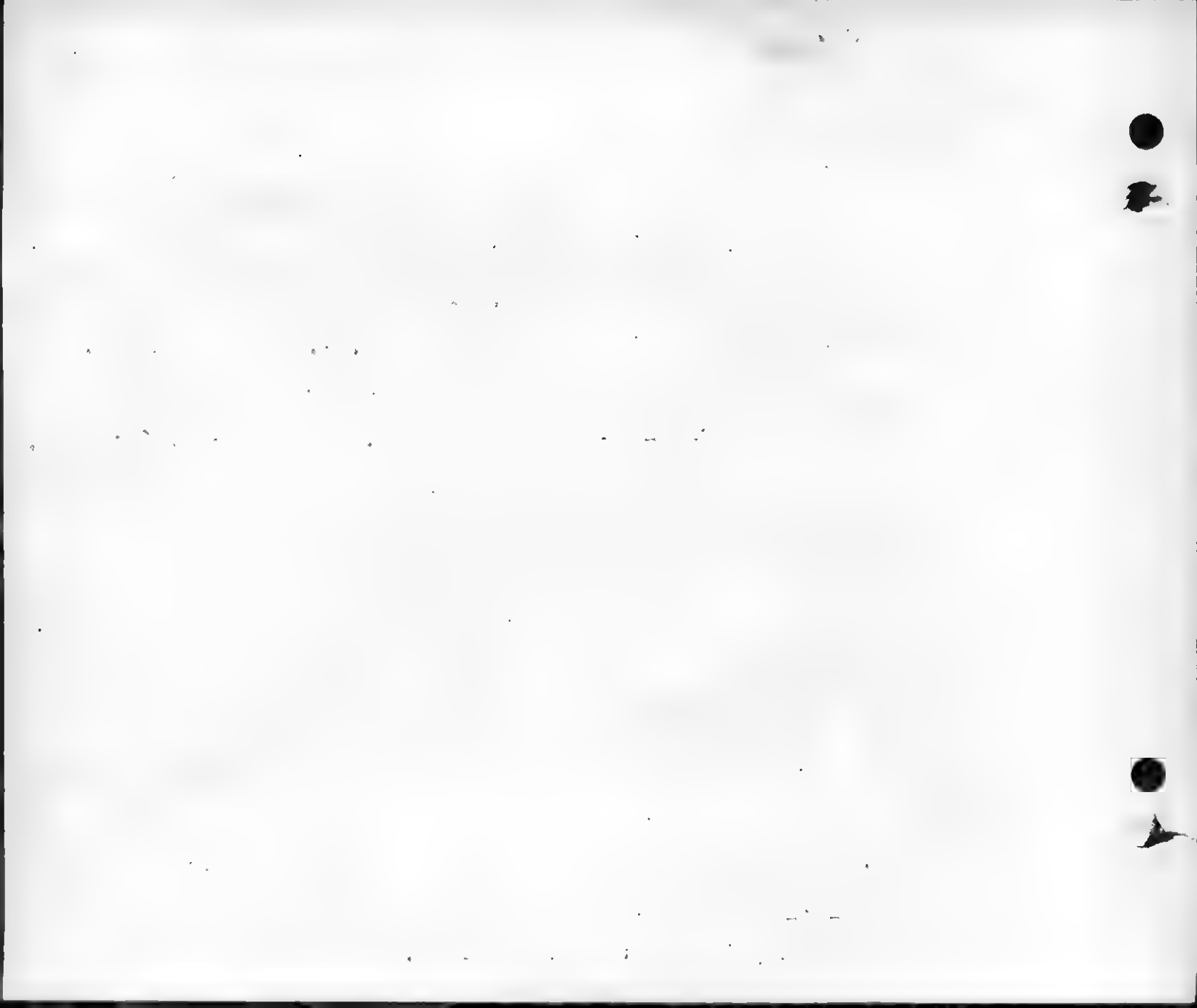
TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1806 CERTIFICATE OF DEATH

Reg. Dist. No. 1785

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hollywood Beach</u> c. LENGTH OF STAY IN 1b <u>20 years</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Chesapeake City</u> d. STREET ADDRESS <u>1 Hollywood Beach</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>C</u> Last <u>Martin</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>17</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 6, 1894</u>
9. AGE (In years, lost birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>11</u> Hours <u>17</u> Min <u>00</u>	11. IF UNDER 24 HRS Hours <u>17</u> Min <u>00</u>
10a. USLA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Motor Court Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Motel</u>	11. BIRTHPLACE (State or foreign country) <u>Buffalo, N. Y.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Martin</u>	
14. MOTHER'S MAIDEN NAME <u>Mattie Greggor</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>222-10-2248</u>		17. INFORMANT Address <u>Mrs. Kathryn M. Martin, Ches. City, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung.</u> DUE TO (b) <u>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.</u> DUE TO (c) <u>Hepatic metastases; Poss Ca of Stomach.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hepatic metastases; Poss Ca of Stomach.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov</u> , 19 <u>60</u> , to <u>Feb 17</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Feb 17</u> , 19 <u>61</u> , and that death occurred at <u>11:30</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Wallore Obenshain M.D.</u> DATE SIGNED <u>18 Feb 61</u>			
22. ACTUAL SIGNATURE <u>Wallore Obenshain</u> M.D.			
23. PHYSICIAN'S NAME (Type) <u>Dr. Wallace Obenshain</u> <u>XXXX</u> <u>Cecilton, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-21-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Freeburg, Penna.</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>PIPPIN FUNERAL HOME</u>		24a. REC'D BY REGISTRAR <u>Feb 21 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>



may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

1807

01788

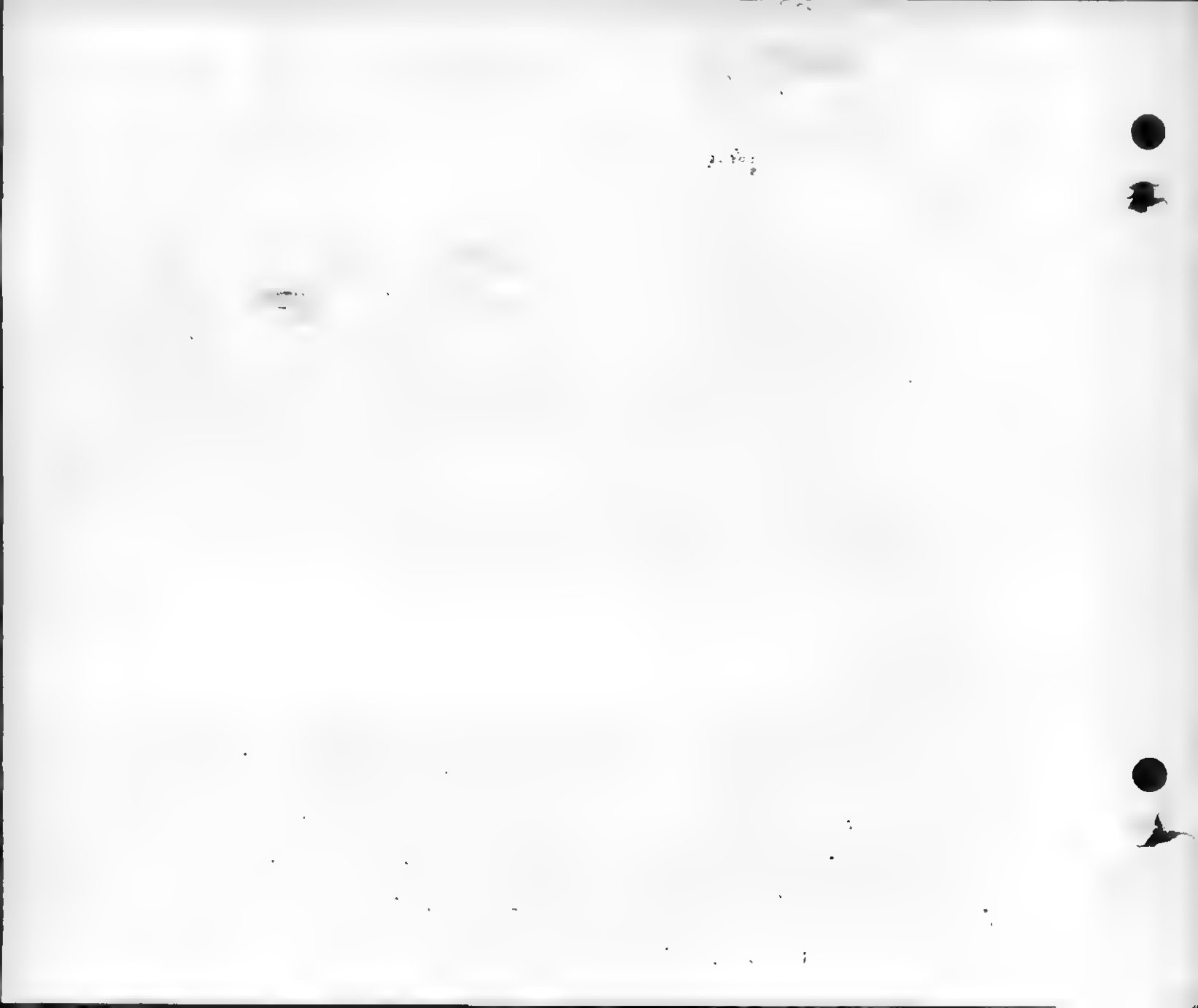
1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>Port Deposit</u>		c. LENGTH OF STAY IN 1b <u>7 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <u>11</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Compton</u>		4. DATE OF DEATH Month Day Year <u>2/ 1/ 1961</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/ 12/ 1898</u>
9. AGE (In years last birthday) <u>62</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>On Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Compton</u>		14. MOTHER'S MAIDEN NAME <u>Mary Yates</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Thomas Meadows</u>		Address <u>Conowingo, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular disease</u> <u>443x</u> DUE TO (b) <u>Mesenteric thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Perforated ulcers</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a m p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 1, 1955</u> to <u>2-1, 1961</u> , that (I) (we) last saw the deceased alive on <u>2-1, 1961</u> , and that death occurred on <u>2-1</u> M, from the causes and on the date stated above			
22a. SIGNATURE <u>G. H. Richards Jr.</u> M.D.		22b. DATE SIGNED <u>2/2/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. H. Richards Jr.</u>		22d. ADDRESS <u>Port Deposit Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/5/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Conowingo Jcn.</u>	23d. LOCATION (City, town, or county) (State) <u>Conowingo Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas E. Mullen</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Thomas</u>	
ADDRESS <u>Port Deposit, Md.</u>		DATE <u>FEB 7 '61</u>	



1808  
CERTIFICATE OF DEATH

Reg. Dist. No. 01787

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X ELKTON			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Memorial				d. STREET ADDRESS 1 Rd # 5		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Florence Molitor				4. DATE OF DEATH Month Day Year Feb 17 1961			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 9, 1888		9. AGE (In years last birthday) 72 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Dela.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME William Brown				14. MOTHER'S MAIDEN NAME Florence McIntire			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		INFORMANT Address Jean Bullock, Pleasant Hill Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X Uremia DUE TO							2 weeks
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetic nephropathy DUE TO							Years
(c) Diabetes Mellitus							Years
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb 13, 1961, to Feb 17, 1961, that I last saw the deceased alive on Feb 17, 1961, and that death occurred at 10 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Tillman D. Salomon M.D.				DATE SIGNED 23 Sincerely Aug 2-17-61			
PHYSICIAN'S NAME (Type) Tillman D. Salomon				ADDRESS (Street, city or town, state) Elkton, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/20/61		22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Meth		22d. LOCATION (City, town, or county) (State) Cherry Hill, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ralph E. Hicks Elkton, Md.				24a. REC'D BY REGISTRAR DATE MAR 1 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	



Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

1809  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01788

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Maryland ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN lb 32yrs. 3mo. 21days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 412 N. Haven	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First KENNETH Middle L. Last MORGAN		4. DATE OF DEATH Month February Day 1 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-3-01
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Herman Morgan		14. MOTHER'S MAIDEN NAME Clara London	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage pulmonary 163 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of the lung DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 minutes Approx. 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a m p m 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that the deceased attended the deceased from October 11, 1961, to February 1, 1961, and that death occurred at M. from the causes and on the date stated above		22a. SIGNATURE E.S. ELLS, M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22b. DATE SIGNED 2-1-61	
22c. PHYSICIAN'S NAME (Type) E.S. ELLS, Chief, Continued Treatment Service, VAH, Perry Point, Md.		22d. ADDRESS	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 2/3/61	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Schimunek Funeral Home, Baltimore, Md. 3331 Brehms Lane		25a. REC'D BY REGISTRAR DATE FEB 3 '61	
25b. REGISTRAR'S SIGNATURE			



1810

# MARYLAND STATE DEPARTMENT OF HEALTH

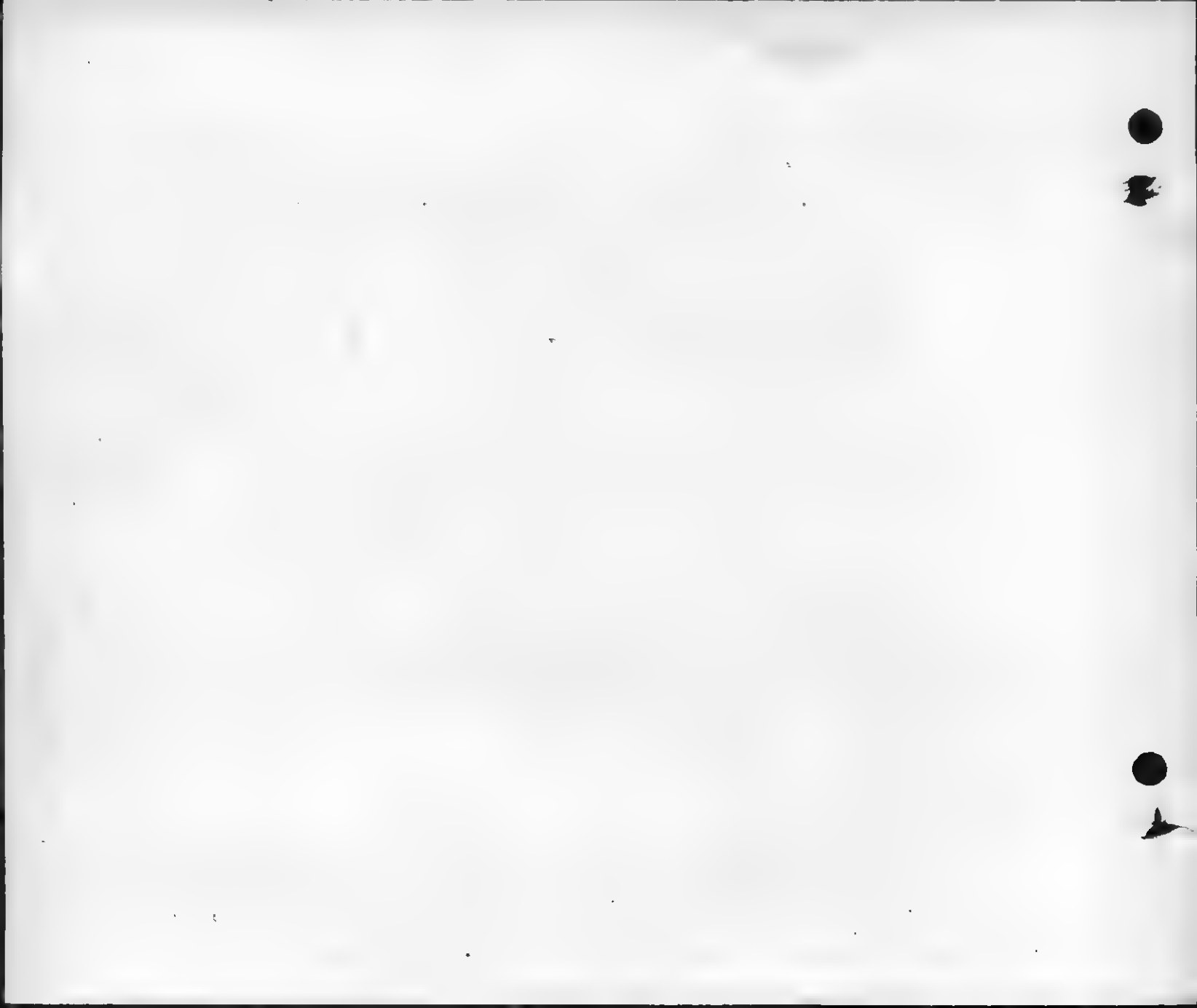
## DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

### CERTIFICATE OF DEATH

01789

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <span style="float: right;">b. COUNTY <b>Cecil</b></span>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>731 S. Main St.</b>				d. STREET ADDRESS <b>731 S. Main St.</b>			
3. NAME OF DECEASED (Type or print) First <b>Grace</b> Middle <b>A. Musselman</b> Last <b>Musselman</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>23</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 8, 1895</b>	
9. AGE (In years last birthday) <b>66 yrs</b>		10. IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min. <b>66</b>		11. IF UNDER 24 HRS Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min. <b>66</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Keeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private Home</b>		11. BIRTHPLACE (State or foreign country) <b>Penn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>David H. Musselman</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Stump</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>160-169772</b>		17. INFORMANT <b>Mrs Fredrick Felpel, Port Deposit, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma Larynx -</b> DUE TO <b>16 IX</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last (b) <b>16 IX</b> DUE TO (c) <b>16 IX</b>						INTERVAL BETWEEN ONSET AND DEATH <b>16 2 yrs</b>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>16 IX</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 1960</b> to <b>Feb 22 1961</b> , that (I) (we) lost saw the deceased alive on <b>Feb 22 1961</b> and that death occurred at <b>M.</b> from the causes and on the date stated above							
22a. SIGNATURE <b>Clarence I. Benson</b>				22b. DATE SIGNED <b>Feb 23 1961</b>		22c. PHYSICIAN'S NAME (Type) <b>Clarence I. Benson</b>	
22d. ADDRESS <b>Port Deposit, Md</b>				22e. MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-25-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Perryville Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Perryville, Pa.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lee A. Patterson &amp; Son</b>				25a. REC'D BY REGISTRAR <b>Feb 28 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

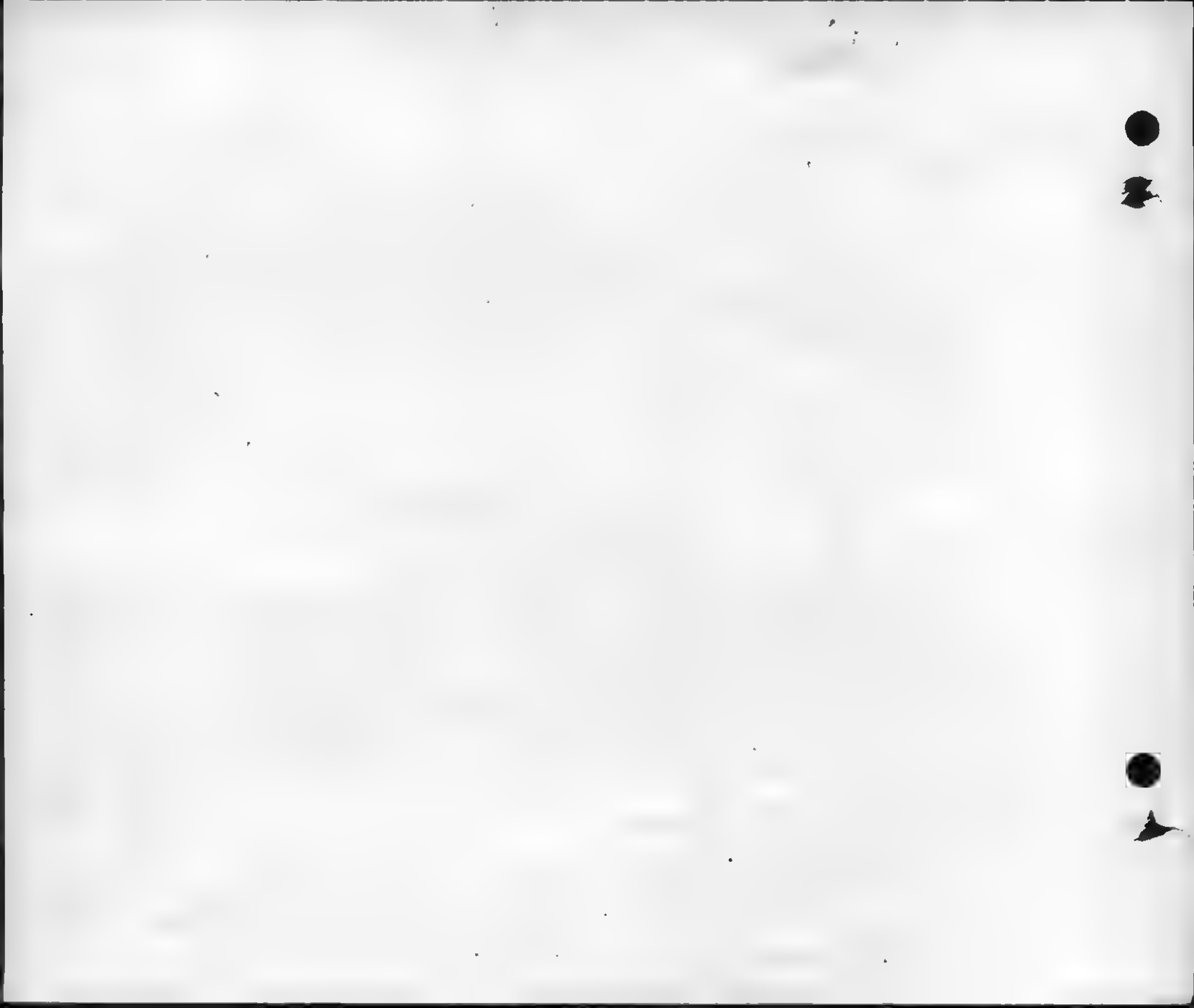
VR A1S (4)  
ISM 9/59

1811

DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01790

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, Rural		c. LENGTH OF STAY IN 1b 58 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Ararat Farms		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary First Hannah Middle Last Pitt		4. DATE OF DEATH Month Feb. Day 23 Year 19 61	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 14, 1881
9. AGE (In years last birthday) 80 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. KIND OF BUSINESS OR INDUSTRY Own home	
13. BIRTHPLACE (State or foreign country) Washington, D.C.		14. CITIZEN OF WHAT COUNTRY? U S A	
15. FATHER'S NAME Henry Bowles		16. MOTHER'S MAIDEN NAME Marcellena Turner	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		18. SOCIAL SECURITY NO. 212-32-1654	
19. INFORMANT Mrs. Alexander Williams, Port Deposit, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592 X DUE TO Chronic Nephritis - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Thyrotoxicosis -		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m p m 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov - 10, 1959 to Feb 22 1961, that (I) (we) last saw the deceased alive on Feb 22 1961, and that death occurred at M, from the causes and on the date stated above.			
22a. SIGNATURE Clarence I. Penson M D		22b. ADDRESS Port Deposit, Md.	
22c. PHYSICIAN'S NAME (Type) Clarence I. Penson		22d. DATE SIGNED Feb 23 1961	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-26-1961	
23c. NAME OF CEMETERY OR CREMATORY Cokesbury Cen.		23d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural	
24. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son, Perryville, Md.		25a. REC'D BY REGISTRAR DATE FEB 28 '61	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

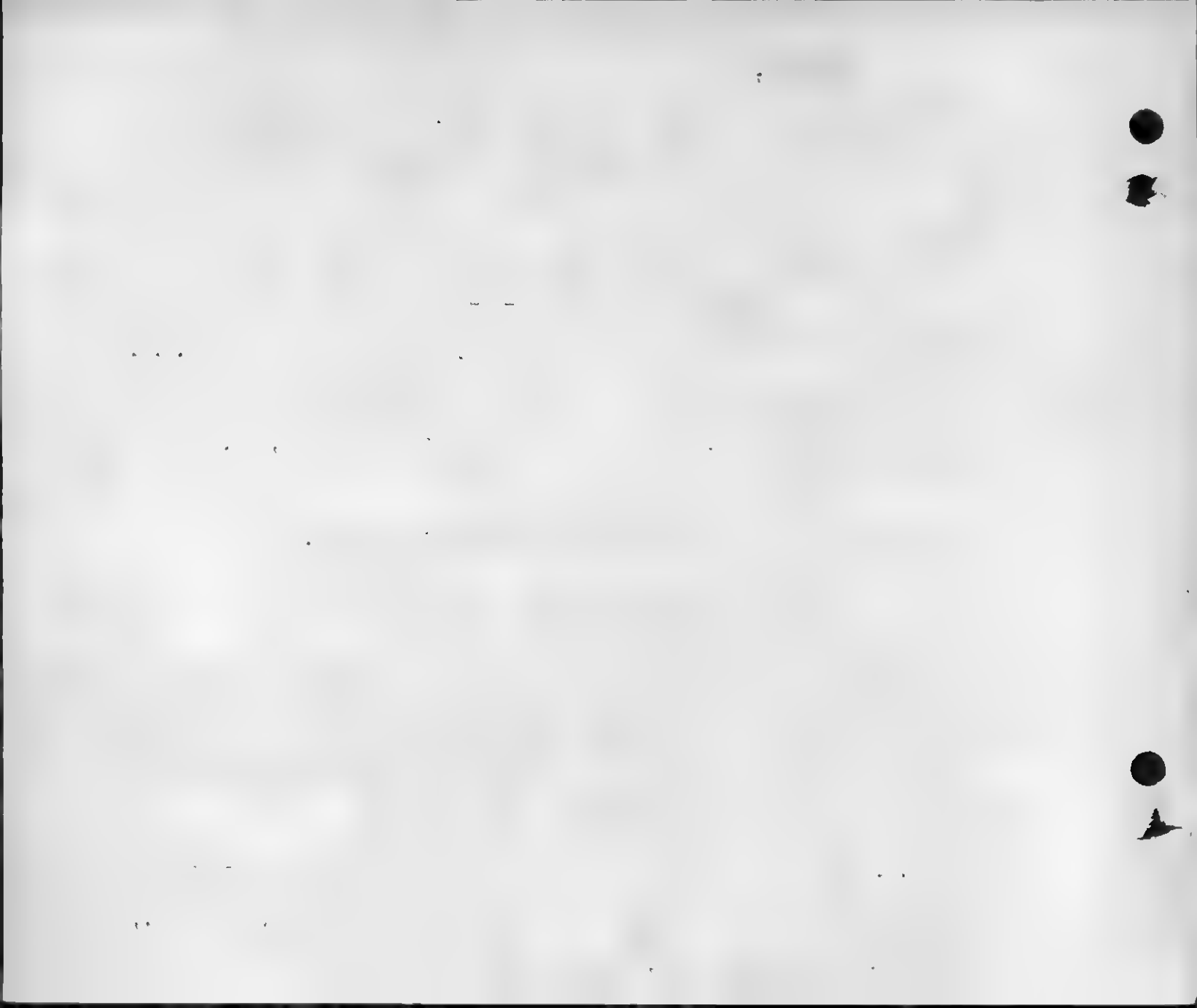
Reg. Dist. No. **01791**

1812

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Cecil</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North East</b> <span style="float: right;">Rural</span> c. LENGTH OF STAY IN lb <b>all life</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived If institution: Residence before admission) a. STATE <b>Md.</b> <span style="float: right;">b. COUNTY <b>Cecil</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North East</b> <span style="float: right;">Rural</span> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
<b>3. NAME OF DECEASED</b> (Type or print) <b>Thomas</b> <span style="float: right;">First</span> <b>Pressley</b> <span style="float: right;">Middle</span> <span style="float: right;">Last</span>				<b>4. DATE OF DEATH</b> <b>2</b> <span style="float: right;">Month</span> <b>15</b> <span style="float: right;">Day</span> <b>1961</b> <span style="float: right;">Year</span>															
<b>5. SEX</b> <b>M</b>		<b>6. COLOR OR RACE</b> <b>W</b>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>3-20-1947</b>		<b>9. AGE</b> (In years last birthday) <b>13</b> <span style="float: right;">yrs.</span>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Child</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Va.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>					
<b>13. FATHER'S NAME</b> <b>Talby Pressley</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>OllieLeeCrabtree</b>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b> <span style="float: right;">(If yes, give war or dates of service)</span>				<b>16. SOCIAL SECURITY NO.</b> <b>-----</b>				<b>17. INFORMANT</b> <b>Talby Pressley</b> <span style="float: right;">Address <b>North East, Md.</b></span>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Cerebral Hemorrhage</b> <b>DUE TO</b> <b>Conditions, if any, which gave rise to immediate cause (b)</b> <b>Epilepsy and deformity since birth.</b> <b>DUE TO</b> <b>(c)</b>												<b>INTERVAL BETWEEN ONSET AND DEATH</b>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)															
<b>20c. TIME OF INJURY</b> <b>19</b> <span style="float: right;">Month, Day, Year</span> Hour <b>a. m.</b> <b>p. m.</b>				<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> <b>Not while</b> <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> <b>(County)</b> <b>(State)</b>											
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>																			
<b>ACTUAL SIGNATURE</b> <i>R. C. Dodson</i> <span style="float: right;">M.D.</span>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <b>2-16-61</b>											
<b>EXAMINER'S NAME (Type)</b> <b>R.C. Dodson</b>				<b>22a. REC'D BY REGISTRAR</b> <b>24b. REGISTRAR'S SIGNATURE</b>															
<b>22b. DATE THEREOF</b> <b>2-18-1961</b>				<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Methodist</b>				<b>22d. LOCATION (City, town, or county)</b> <b>(State)</b> <b>North East, Cecil Co., Maryland</b>											
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Joseph R. Grant</i> <span style="float: right;">ADDRESS <b>North East, Maryland</b></span>				<b>24a. REC'D BY REGISTRAR</b> <b>24b. REGISTRAR'S SIGNATURE</b>															

MEDICAL CERTIFICATION

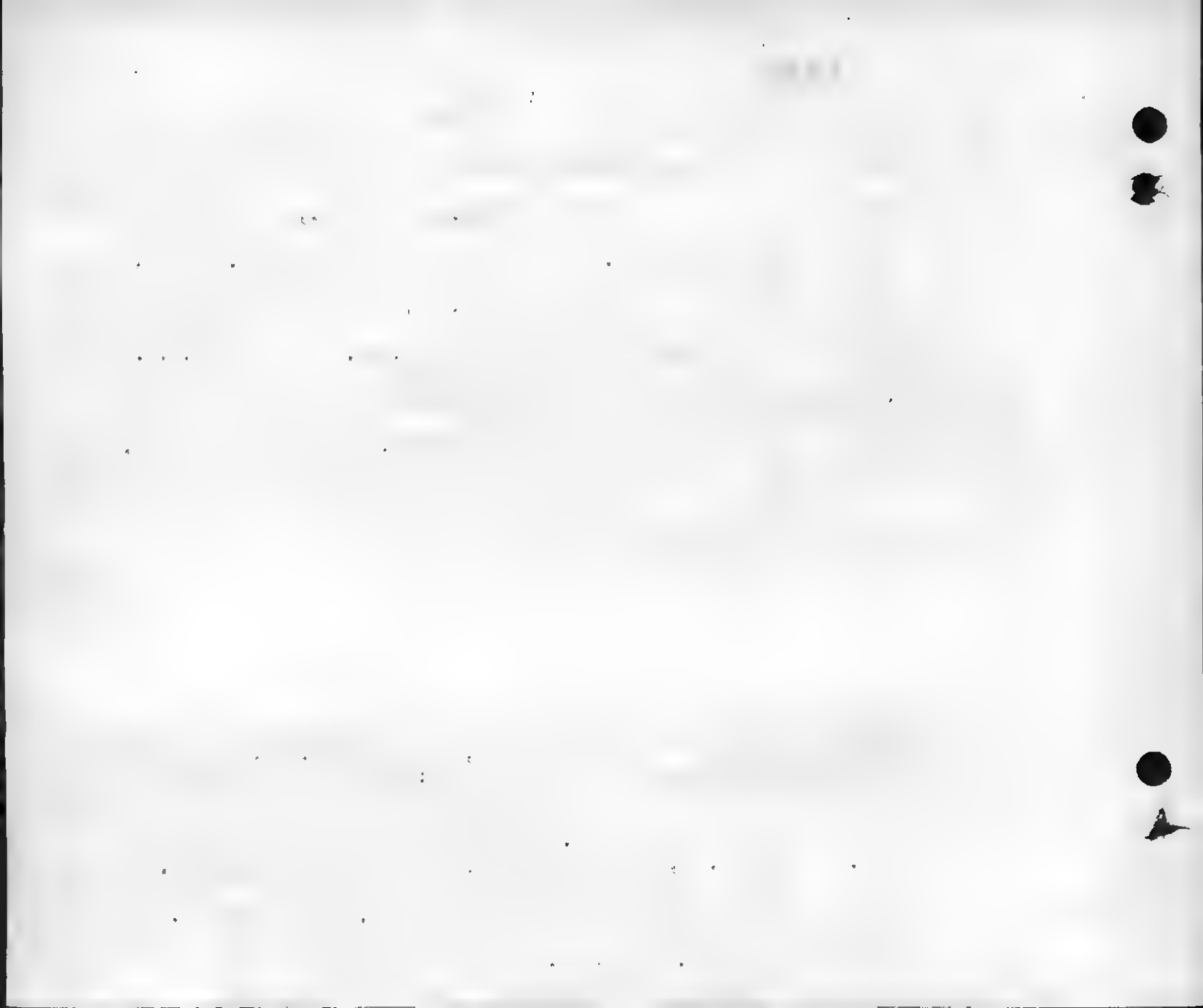
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, leave executed the certificate, with the word "pending," in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. Forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



## 01792

1813

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>35yr3mo26days</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Veterans Hoospital</b>	
3. NAME OF DECEASED (Type or print) <b>EMMITT</b>		First <b>G.</b>		Middle <b>ROBERTSON</b>		Last	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 24, 1937</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bookkeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Nathan R. Robertson</b>				14. MOTHER'S MAIDEN NAME <b>Annie Young</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW1</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b>							
420.0 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerotic heart disease</b>							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (X) (the hospital) attended the deceased from <b>July 26, 1925</b> to <b>Feb. 18, 1961</b> , and that death occurred <b>4:50 PM</b> from the causes and on the date stated above							
22a. SIGNATURE <b>Albert L. Mooney</b>				M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>2-19-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>ALBERT L. MOONEY, M.D., Pathologist VAH, Perry Point, Maryland.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>2/25/1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town, or county) (State) <b>Ft. Myer, Virginia.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>PENNINGTON &amp; SON</b>				ADDRESS <b>Havre De. Grace, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 28 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>							



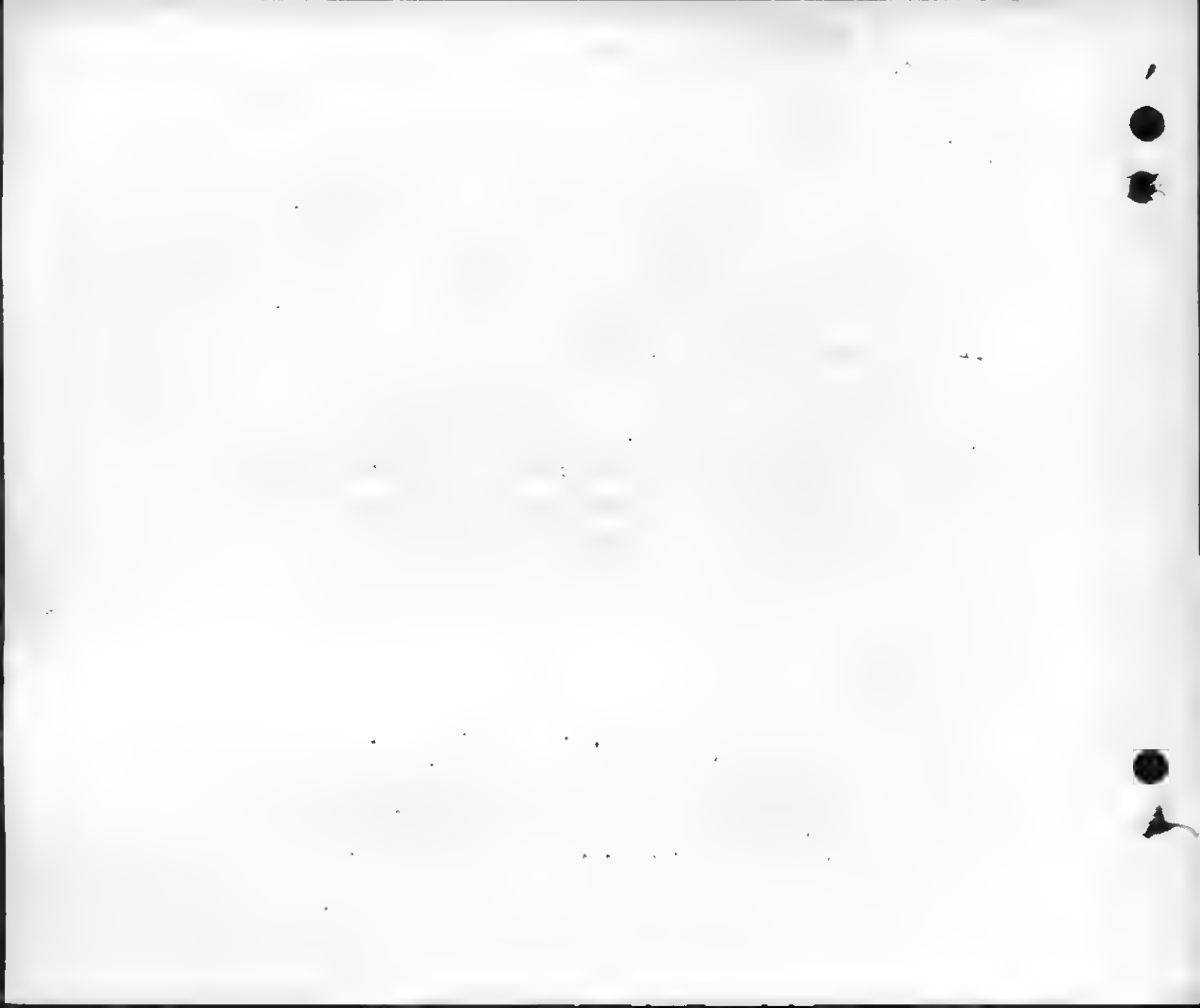
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1814

## CERTIFICATE OF DEATH

Reg. Dist. No. **01793**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Cecil</b> <span style="float: right;">MARYLAND</span>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Cecil</b></span>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b <b>10 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Mae</b> Middle <b>Louise</b> Last <b>Rowen</b>		<b>4. DATE OF DEATH</b> Month <b>2</b> Day <b>15</b> Year <b>19 61</b>	
<b>5. SEX</b> <b>F.</b>		<b>6. COLOR OR RACE</b> <b>W.</b>	
<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>May 10, 1896</b>	
<b>9. AGE</b> (In years lost birthday) <b>64 yrs</b>		<b>10. IF UNDER 1 YEAR</b> Months <b>6</b> Days <b>4</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>House Work</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Penna.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>John Cato</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Unkn.</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b>	
<b>INFORMANT</b> <b>Mrs Thomas McCarthy</b>		<b>Address</b> <b>Rd #4, Elkton, Md.</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause pertaining to (a) - (b) - (c)] <b>Arteriosclerotic coronary heart disease with severe angina pectoris</b> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>severe angina pectoris</b> DUE TO (b) <b>unknown</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)	
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>1:40 p.m.</b> <b>19 61</b>	
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b> <b>Elkton</b> (County) (State)		<b>21. I certify that I attended the deceased from</b> <b>Sept. 18, 1960</b> , <b>that I last saw the deceased alive on</b> <b>Feb. 15, 1961</b> , <b>and that death occurred at</b> <b>1:40 p.m.</b> , <b>from the causes and on the date stated above.</b>	
<b>ACTUAL SIGNATURE</b> <b>S. Ralph Andrews, Jr.</b> M.D.		<b>ADDRESS</b> (Street, city or town, state) <b>233 E. Main Street</b>	
<b>PHYSICIAN'S NAME (Type)</b> <b>S. Ralph Andrews, Jr., M.D.</b>		<b>DATE SIGNED</b> <b>2/15/61</b>	
<b>22a. BURIAL, CREMATATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>2/18/61</b>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Elkton Cemetery</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>Elkton, Maryland</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W. Walter de Boer</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE FEB 23 '61</b>	
<b>ADDRESS</b> <b>Elkton Md.</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



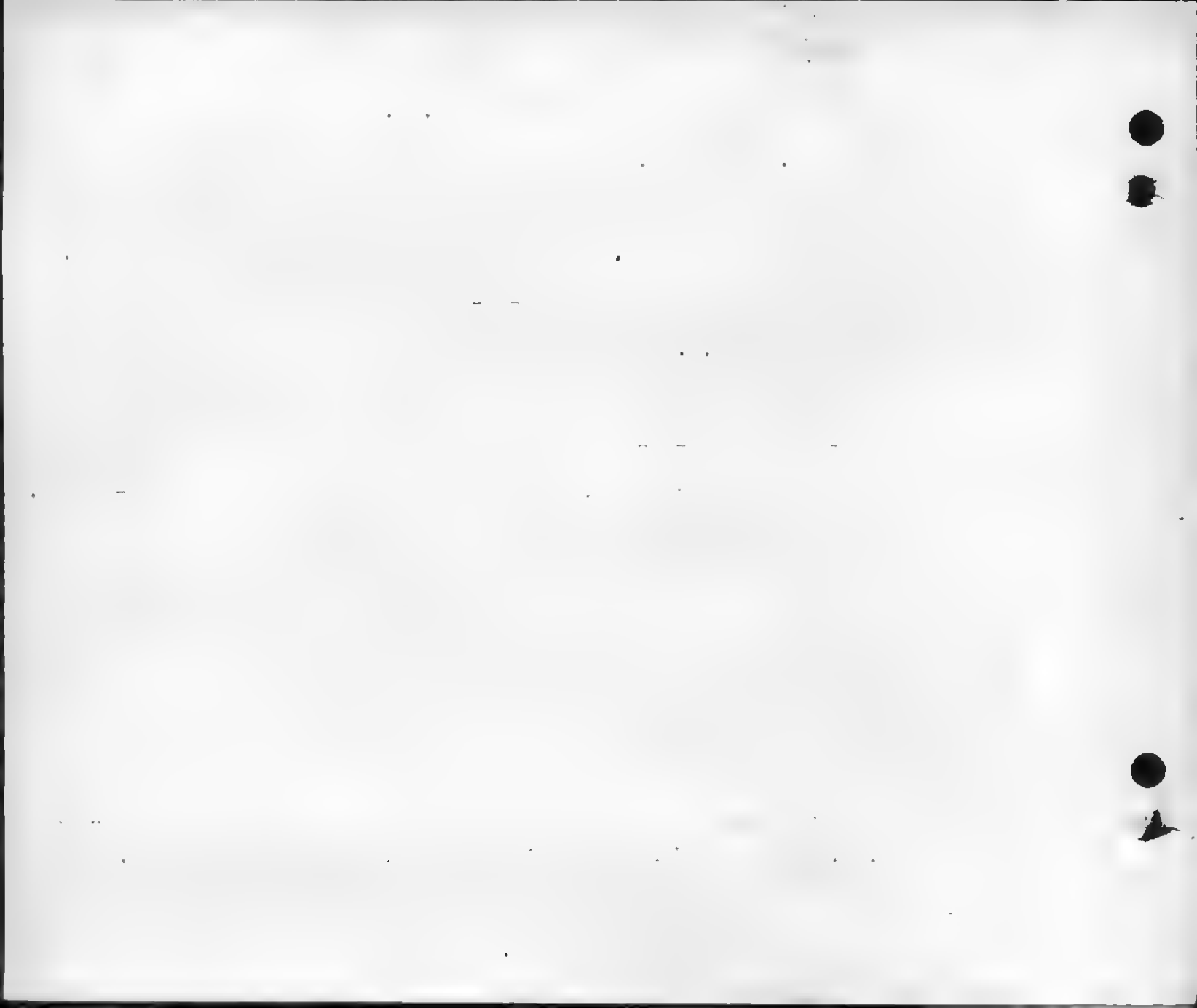
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

1815  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01796

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Md.				c. LENGTH OF STAY IN 1b 2 mo. 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 156 Todd Place N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last THOMAS J. SAVOY				4. DATE OF DEATH Month Day Year February 27 1961			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-15-92	
9. AGE (In years last birthday) 68 yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Savoy (deceased)				14. MOTHER'S MAIDEN NAME Lottie Harding (deceased)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW-1				16. SOCIAL SECURITY NO. 142-12-7040		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Peritonitis diffuse DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Adenocarcinoma, sigmoid, recurrent with widespread metastasis (c) unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH 48-72 hrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that <del>XXXXXXXXXXXX</del> attended the deceased from December 15, 1960, to February 27, 1961, and that death occurred at 2:50 pm from the causes and on the date stated above.							
22a. SIGNATURE A. L. MOONEY, M.D.				22b. DATE SIGNED 2-28-61		22c. PHYSICIAN'S NAME (Type) A. L. MOONEY, Asst. Clinical Pathologist, VAH, Perry Point, Md.	
23a. BURIAL CREMATION REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 3/3/1961		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.				25a. REC'D BY REGISTRAR DATE MAR 7 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1816

CERTIFICATE OF DEATH

Reg. Dist. No. 01795

1. PLACE OF DEATH o. COUNTY <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural North East</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural North East</b>	
c. LENGTH OF STAY IN 1b <b>39 yrs</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>-</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>-</b>		e. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>R.</b> Last <b>Shifflett</b>		4. DATE OF DEATH Month <b>2</b> Day <b>15</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 10, 1880</b>
9. AGE (In years lost birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm owner</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>no information</b>		14. MOTHER'S MAIDEN NAME <b>no information</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>William F. Shifflett North East, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> <b>442 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardiovascular Renal Disease</b> DUE TO (c) <b>3 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. <b>15</b> p. m. <b>15</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 1959</b> , to <b>15 Feb. 1961</b> , that I last saw the deceased alive on <b>15 Feb. 1961</b> , and that death occurred at <b>4:45 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Klaus H. Huebner</b>		DATE SIGNED <b>2/15/61</b>	
PHYSICIAN'S NAME (Type) <b>Klaus H. Huebner M.D.</b>		ADDRESS (Street, city or town, state) <b>No. 14 East St</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-19-1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Methodist</b>	22d. LOCATION (City, town, or county) (State) <b>North East, Cecil Co., Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Grant</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 23 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Trause</b>			



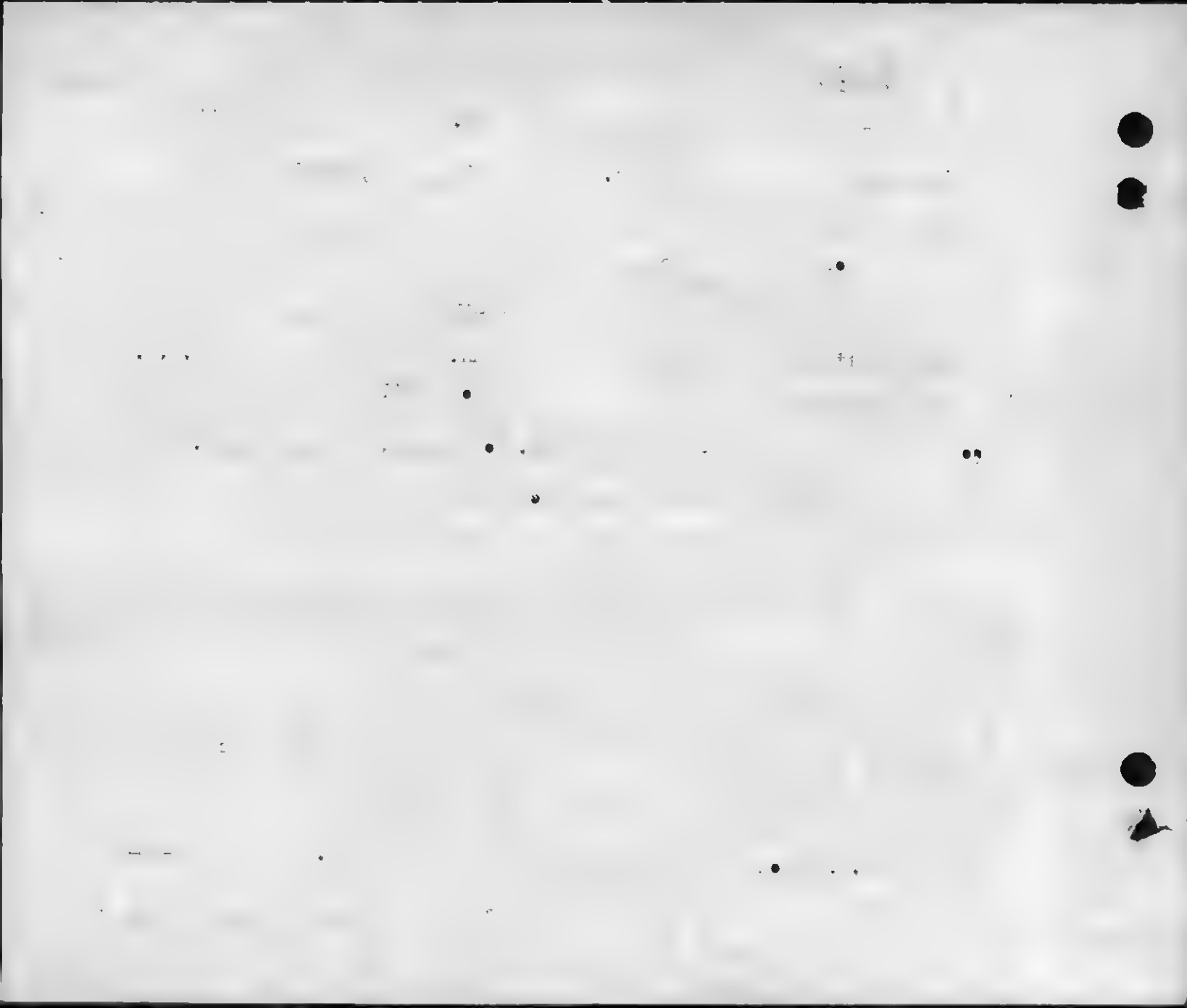
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death occurs on a Sunday, the certificate should be executed on the following Monday. Give Pages 1, 2, and 3 to the funeral director. Give Pages 4 and 5 to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1817-  
MAYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01796

1. PLACE OF DEATH a. COUNTY <u>Cecil</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun, Rural</u>		
c. LENGTH OF STAY IN 1b <u>1</u> hrs.			d. STREET ADDRESS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					
3. NAME OF DECEASED (Type or print) First <u>Bob</u> Middle <u>Roy</u> Last <u>Thomas</u>			4. DATE OF DEATH Month <u>2</u> Day <u>19</u> Year <u>1961</u>		
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>5-8-1886</u>		9. AGE (In years last birthday) <u>74</u> yrs		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer Retired</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		
11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Jasper Thomas</u>			14. MOTHER'S MAIDEN NAME <u>Polly Wilson</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)			16. SOCIAL SECURITY NO. <u>413-26-5039</u>		
17. INFORMANT <u>Mrs. Bob Thomas, Rising Sun, Md.</u>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u>					
DUE TO (b) <u>  </u>					
DUE TO (c) <u>  </u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL EXAMINER'S NAME (Type) <u>R.C. Dodson</u>					
CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Rising Sun, Md.</u> Address (Street, city, town, or county)					
DATE SIGNED <u>2-19-61</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>2-23-1961</u>		
22c. NAME OF CEMETERY OR CREMATORY <u>Union cem.</u>			22d. LOCATION (City, town, or country) (State) <u>Mabel N.C.</u>		
23. FUNERAL DIRECTOR <u>Thomas E. McPherson</u>			24a. REC'D BY REGISTRAR <u>Rising Sun, Md.</u>		
24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>			DATE <u>FEB 21 '61</u>		



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1818

01297

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Cecil</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u> c. LENGTH OF STAY IN 1b <u>Lifetime</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>17 Granite Street</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u> d. STREET ADDRESS <u>117 Granite St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>Mary Josephine Townsend</u>		<b>4. DATE OF DEATH</b> <u>Feb 4 1961</u>		<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>Negro</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>March 9, 1901</u>		<b>9. AGE</b> (In years last birthday) <u>59</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Mins. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Housewife</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Port Deposit, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>		<b>13. FATHER'S NAME</b> <u>George E. Stewart</u>			
<b>14. MOTHER'S MARRIAGE NAME</b> <u>Alice Lee Thomas</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>				<b>16. SOCIAL SECURITY NO</b> <u>none</u>			
<b>17. INFORMANT</b> Address <u>Br. 102</u> <u>Mr. William T. Bullock, Lexington, Md.</u>											
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cor. Myocardial</u> 455.5 } DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (c) <u>  </u> DUE TO (e), stating the underlying cause last. (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Coron. Myocardial</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>  </u> 20c. TIME OF INJURY: Month, Day, Year <u>Feb 3 1961</u> Hour a.m. <u>  </u> p.m. <u>  </u> 20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u> 20f. (City or town) <u>Port Deposit</u> (County) <u>Cecil</u> (State) <u>Md.</u> 21. I certify that (I) (this hospital) attended the deceased from <u>Feb 3 1961</u> to <u>Feb 3 1961</u> , that (I) (we) last saw the deceased alive on <u>Feb 3 1961</u> , and that death occurred at <u>  </u> M., from the causes and on the date stated above. 22. SIGNATURE <u>Carouse H. Benson</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>  </u> 22d. ADDRESS <u>Port Deposit, Md.</u> 22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22f. DATE SIGNED <u>Feb 5 1961</u> 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Feb 7 1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Cokebury Cemetery</u> 23d. LOCATION (City, town or county) <u>Cokebury, Cecil Co. Md.</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>Otilia J. Bullock, Howard Grove, Md.</u> ADDRESS <u>538 E. 1st St.</u> 25a. REC'D BY REGISTRAR <u>FEB 8 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>											

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1819

## CERTIFICATE OF DEATH

Reg. Dist. No. 01798

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 41 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Main & North Streets		d. STREET ADDRESS Main & North Streets 1	
3. NAME OF DECEASED (Type or print) GEORGE First DIMITRIOS Middle VAGGI Last		4. DATE OF DEATH Feb. 8, 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 23, 1890
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hotel		10b. KIND OF BUSINESS OR INDUSTRY Owner	
11. BIRTHPLACE (State or foreign country) Kythera, Greece		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dimitrios Vaggi		14. MOTHER'S MAIDEN NAME Evangiline No Inf.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-32-9209	
17. INFORMANT Mrs. Mary G. Vaggi, Elkton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute coronary thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic hypertensive cardiosascular disease (c) unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 30 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 7, 1961 to Feb. 7, 1961, that I last saw the deceased alive on Feb. 7, 1961, and that death occurred at 5:45 P.M. from the causes and on the date stated above.		22. ADDRESS (Street, city or town, state) 233 E. Main Street DATE SIGNED 2/8/61	
ACTUAL SIGNATURE S. Ralph Andrews, Jr. M.D.		PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D. Elkton Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-11-61	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO THE HONORABLE SECRETARY OF THE  
NAVY  
WASHINGTON, D. C.

SIR:

I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above subject.

The Bureau has no objection to the proposed action.

Very respectfully,  
Yours truly,  
[Signature]

Enclosed for the Bureau are two copies of the report of the [Name] dated [Date].

Very truly yours,  
[Signature]

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
1820 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
01799											
1. PLACE OF DEATH a. COUNTY <b>Cecil</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bainbridge</b>						c. LENGTH OF STAY IN TB <b>1 mo. 29 days</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S. Naval Traing Hospital</b>						e. STREET ADDRESS <b>119C Preston Drive Manor Heights</b>					
3. NAME OF DECEASED (Type or print) <b>Jo Layne Marie Young</b>						4. DATE OF DEATH <b>2 7 19 61</b>					
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-8-60</b>		9. AGE (in years last birthday) <b>1 29</b>		10. IF UNDER 1 YEAR <b>1 29</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Infant</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Robert David Young</b>		14. MOTHER'S MAIDEN NAME <b>Donna Marie Cameron Md.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Robert Davis Young, 119C Preston Drive Manor Heights, Port Depos</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Oedema</b> 522X DUE TO (b) <b>( Pending chemical examination, iff different another</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>certificate will be issued).</b>		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <b>R.C. Dodson</b>		EXAMINER'S NAME (Type) <b>R.C. Dodson</b>		DATE SIGNED <b>2-7-61</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-9-1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cherry Creek Cem .</b>	
22d. LOCATION (City, town, or country) (State) <b>Cherry Creek, New York</b>		23. FUNERAL DIRECTOR <b>Veera Patterson &amp; Son,</b>		ADDRESS <b>Perryville, Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 9 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>		25. (State, city, town, or county)	

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